UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

In re: Guidant Corp. Implantable Defibrillators Products Liability Litigation	MDL No. 05-1708 (DWF/AJB)
This Document Relates to All Actions	**PLAINTIFF'S FACT SHEET**

PLAINTIFF'S FACT SHEET

Each Plaintiff who was implanted with a Guidant defibrillator or a pacemaker or combination defibrillator/pacemaker must complete this Fact Sheet. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge, information and belief. If you cannot recall all the details requested, please provide as much information as you can if the response to any question is that the person completing this Fact Sheet does not know or does not recall the information requested, that response should be entered in the appropriate location(s). You may and should consult with your attorney, if you have any questions regarding the completion of this form.

If you are completing this form for someone who has died or who cannot complete the Fact Sheet for him or herself, please answer as completely as you can for that person. You may attach as many sheets of paper as are necessary to answer these questions fully.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Caption: _____

2. Civil Action No.: _____

3. Court in which action originally brought (transferor district):

_____

4. Original civil action number in the transferor court. Civil Action No.:

_____

5. Please state name, address, telephone number, fax number and E-mail address of primary attorney representing you.

_____

Name

_____

Firm

_____

Street Address

_____

City, State and Zip Code

_____ _____

Telephone number Fax number

_____

E-mail address

B. If you are completing this questionnaire in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

1. _____

Your Name

2. _____

Street Address

3. _____

City, State and Zip Code

4. In what capacity are you representing the individual:

_____

5. If you were appointed by a court, state the:

_____ _____

Court Date of Appointment

6. Your relationship to deceased or represented person:

_____

7. If you represent a decedent's estate, state the date of death and cause of death of the decedent.

_____

8. If you represent a decedent's estate, provide a copy of the decedent's death certificate and autopsy report (if conducted).

C. [If you are completing this questionnaire in a representative capacity, please respond to the remaining questions with respect to the person who received a Guidant Implantable Defibrillator and/or Pacemaker. Those questions using the term "You" refer to the person who received an implantable defibrillator and/or pacemaker. If the individual is deceased, please respond as of the time immediately prior to his or her death unless a different time period is specified.]

1. Do you claim that you have suffered a bodily injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker?
Yes _____ No _____

2. If the answer to the foregoing questions is "Yes", state the nature of the injury or injuries which you claim.

_____

3. If you do not claim you have suffered a bodily injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker, state how you have been injured or describe the losses you are claiming. _____

II. PERSONAL INFORMATION

A. Last Name: _____

First Name: _____

Middle Name or Initial: _____

B. Maiden or other names used or by which you have been known, including alias/nicknames:

_____

C. Present Street Address:

_____

City State Zip Code

D. How long have you lived at this address? _____

E. Current or last employer:

_____
Name

_____
Address

_____
Dates of Employment

_____
Occupation

F. Social Security Number: _____

G. Date and Place of Birth: _____

H. Sex: Male _____ Female _____

Answer questions I-K only if you claim that you have suffered a bodily injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker.

I. Have you ever filed a worker's compensation claim?
Yes _____ No _____

If yes, please state

1. Year claim was filed: _____

2. Where claim was filed: _____

3. Claim/docket number, if applicable: _____

4. Nature of disability: _____

5. Period of disability: _____

6. Address of claims office: _____

7. Whether the claim was settled and amount of any settlement: _____

_____

[Attach additional sheets if necessary to describe more than one claim]

J. Have you ever filed a social security disability claim?
Yes _____ No _____

1. If yes, please state

a. Year claim was filed: _____

b. Where claim was filed: _____

c. Nature of disability: _____

d. Period of disability: _____

e. Address of claims office: _____

f. Monthly amount of any disability payments: _____

g. Amount of any lump sum settlement: _____

h. [Attach additional sheets if necessary to describe more than one claim]

K. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?
Yes _____ No _____

If so, state the court in which such action was filed and the civil action or docket number assigned to each such claim, action or suit, and whether you were deposed or gave your testimony at trial.

_____

III. MARITAL STATUS

A. Are you currently married?
Yes _____ No _____

B. Has your spouse filed a loss of consortium claim?
Yes _____ No _____

C. Spouse's name: _____

D. Spouse's date of birth: _____

E. Spouse's occupation: _____

F. If not currently married, do you have any former spouses who have filed loss of consortium claims?
Yes _____ No _____

G. If any former spouses have filed loss of consortium claims, please provide:

1. Name of former spouse: _____

2. Date of birth of former spouse: _____

3. Date of marriage to former spouse: _____

4. Date of dissolution of marriage from former spouse: _____

IV. IMPLANT/EXPLANT INFORMATION

A. If you received a Guidant implantable defibrillator and/or pacemaker, which you have made a claim of injury, please state:

1. The date of implantation: _____

2. The name and address of the prescribing physician: _____

_____

_____

3. The name and address of the implanting surgeon: _____

_____

_____

4. The specific make, model, lot number and serial number of the Guidant implantable defibrillator and/or pacemaker you received:

_____

5. Name of hospital where implant was conducted: _____

_____

_____

B. After your Guidant defibrillator and/or pacemaker was implanted, did you participate in regular follow up with your doctor(s) about it.

Yes _____ No _____ I don't know _____

If yes:

1. How often did you follow up with your doctor(s) about your Guidant defibrillator and/or pacemaker _____

2. During this follow up, was your Guidant defibrillator and/or pacemaker ever tested by a doctor or a Guidant representative

Yes _____ No _____ I don't know _____

If yes please provide:

a. Dates of testing: _____

b. Location of testing: _____

c. Testing by (name & address): _____

d. Results of testing, if you know: _____

_____

C. Were you given any written instructions, warnings or other information regarding the implantation of the Guidant defibrillator and/or pacemaker?

Yes _____ No _____ I don't know _____

1. If "yes," when did you receive the information: _____

2. Who gave you the information? _____

3. Do you have the written information in your possession? If so, please produce a copy of it together with your answers to the Plaintiff's Fact Sheet.

4. If you no longer have the written information in your possession, please describe the information that you received to the best of your ability.

_____

_____

D. Were you ever given any oral instructions, warnings or other information regarding your Guidant Implantable pacemaker and/or defibrillator?

Yes _____ No _____ I don't know _____

1. If "yes," when did you receive those instructions? _____

2. Who gave those instructions to you? _____

3. Please describe the oral instructions you received to the best of your ability: _____

_____

_____

E. If you had your Guidant implantable defibrillator and/or pacemaker explanted, please state:

1. The date of explant: _____

2. The reason for the explant: _____

3. The name and address of the explanting surgeon: _____

_____

_____

4. Name and address of hospital where explant was conducted: _____

_____

_____

5. The present location of the explanted defibrillator and/or pacemaker:

_____

_____

6. If your explanted Guidant defibrillator and/or pacemaker has not been returned to Guidant, has it been tested?

Yes _____ No _____ I don't know _____

a. If "yes," when was it tested? _____

_____

b. Dates of testing: _____

c. Location of testing: _____

d. Testing by (name & address): _____

e. Results of testing, if you know: _____

_____

7. During your explant surgery, was a replacement defibrillator and/or pacemaker implanted?
Yes _____ No _____

8. If yes, state the manufacturer, make, model, lot number and serial number of the replacement defibrillator and/or pacemaker:

_____

_____

_____

9. Did you pay for the explant surgery and the replacement defibrillator and/or pacemaker?
Yes _____ No _____

10. If not, state who paid for the explant surgery and the replacement defibrillator and/or Pacemaker: _____

_____

F. If you have not had your Guidant implantable defibrillator and/or Pacemaker explanted, do you presently plan to have the device explanted?
Yes _____ No _____

If yes, please provide:

1. The date scheduled for explant surgery: _____

2. The name of the explanting surgeon: _____

3. The name and address of the hospital where the explant surgery will be performed: _____

_____

_____

4. The reason for the explant surgery: _____

_____

5. Has any doctor ever told you that you need to have your Guidant Implantable defibrillator and/or pacemaker explanted?

Yes _____ No _____

If yes, provide name and address of each such doctor:

_____

_____

_____

For each doctor listed, provide the date that the doctor told you that you need to have your Guidant implantable defibrillator and/or pacemaker explanted:

_____

_____

_____

6. Has any doctor told you that your medical condition prevents you from having your Guidant Implantable defibrillator and/or pacemaker explanted?

Yes _____ No _____

If yes, provide the name and address of each such doctor:

_____

_____

_____

If yes, identify the medical condition: _____

G. If you presently have an implanted defibrillator and/or pacemaker, please state the manufacturer, make, model, lot number and serial number of that device: _____

_____

_____

V. YOUR MEDICAL HISTORY

A. Age: _____

B. Height: _____

C. Current weight: _____

D. Condition for which the Guidant defibrillator and/or pacemaker was indicated:

_____

_____

E. Current status of condition for which the Guidant defibrillator and/or pacemaker was implanted:

_____

F. Have you had any of the following tests or procedures in the past 10 years?

Electrophysiology study: Yes _____ No _____ I don't know _____

Cardiac Catheterization: Yes _____ No _____ I don't know _____

If "yes," please complete the following. If you cannot remember all the details, please list as much information as you can.

a. Type of test: _____

b. Date administered: _____

c. Reason for test: _____

d. Facility name & address: _____

_____

e. Ordering doctor: _____

f. Results/diagnosis: _____

(Attach additional pages, as necessary.)

VI. OTHER MEDICAL INFORMATION

A. To the best of your knowledge, have you ever been told by a doctor or any other health care provider, that you have, may have or had any of the following:

1.	Hypertension or high blood pressure	Yes _____ No _____
2.	Heart valve problems	Yes _____ No _____
3.	Heart attack	Yes _____ No _____
4.	Stroke	Yes _____ No _____
5.	Any kind of blood clot	Yes _____ No _____
6.	Pulmonary embolism	Yes _____ No _____
7.	Congenital abnormality of heart	Yes _____ No _____
8.	Immune system disease or dysfunction (including Aids or HIV)	Yes _____ No _____
9.	Rheumatic fever	Yes _____ No _____
10.	Cirrhosis, hepatitis or other liver disease	Yes _____ No _____

11.	Alcoholism	Yes _____No _____
12.	Cancer(s) If yes, specify: _____	Yes _____No _____
13.	Pulmonary hypertension	Yes _____No _____
14.	Neurological problem If yes, specify: _____	Yes _____No _____
15.	Cardiac arrhythmias	Yes _____No _____
16.	Endocarditis	Yes _____No _____
17.	Any cholesterol problem	Yes _____No _____
18.	Diabetes mellitus or other form of diabetes If yes, specify the type: _____	Yes _____No _____
19.	Kidney disease	Yes _____No _____
20.	Any connective tissue disease (e.g. Marfan's, Lupus or Arthritis)	Yes _____No _____
21.	Other autoimmune disease If yes, specify: _____	Yes _____No _____
22.	Thyroid disorder	Yes _____No _____
23.	Coronary artery disease	Yes _____No _____
24.	Other heart or lung disease	Yes _____No _____
25.	Gum disease, tooth infection or abscess	Yes _____No _____
26.	Transient ischemic attack (TIA)	Yes _____No _____
27.	Hypotension (low blood pressure)	Yes _____No _____
28.	Carotid artery disease	Yes _____No _____
29.	Aortic aneurysm	Yes _____No _____
30.	Urinary infection	Yes _____No _____
31.	Syncope	Yes _____No _____
32.	Light-headedness	Yes _____No _____
33.	Dizziness	Yes _____No _____

34. Bradycardia Yes _____ No _____

35. Sudden cardiac death Yes _____ No _____

36. Cardiomyopathy (hypertensive, ischemic) Yes _____ No _____

37. Neuromuscular diseases (muscular dystrophy, etc.) Yes _____ No _____

38. Tachycardia Yes _____ No _____

B. If you responded yes to any of the above, please identify the condition, the date of onset and state the name of the physician or other person and, if not provided in the accompanying list, the address of the physician who made the diagnosis or informed you of the condition. (Use extra page if necessary.)

1. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____

2. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____

3. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____

4. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____

5. Condition: _____
   Onset: _____
   Name and address of diagnosing physician or other person:
   _____

C. State the name and address of your current family/primary care physician:

_____

D. State the name and address of each of your family/primary care physicians going back 10 years.

_____

E. State the name and address of each cardiologist, cardiac electrophysiologist, cardiac surgeon and/or thoracic surgeon that has ever seen or treated you.

_____

F. State the name and address of each hospital or surgery center where you have ever received treatment in the last 10 years.

_____

G. State the name and address of each other physician or healthcare provider from whom you ever received treatment in the last 10 years.

_____

H. State the name and address of each pharmacy, drugstore or any other facility where you ever received any prescription medication in the last ten years.

_____

VII. ALLEGED INJURIES, ILLNESS AND DAMAGES

A. If you are making a claim for physical injuries or illness as a result of your Guidant defibrillator and/or pacemaker, please describe the following:

1. Nature of physical injuries or illness: _____

2. The date you first became aware of the physical injuries or illness:

_____

3. How you first became aware of the physical injuries or illness:

_____

4. Are those injuries or illness continuing?: _____

5. Did you see a doctor, clinic or other healthcare provider for the physical injuries or illness listed above?

Yes _____ No _____ I don't know _____

B. If you claim psychological or emotional injury as a consequence of having a Guidant implantable defibrillator and/or Pacemaker, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem prior to the use of a Guidant implantable defibrillator and/or Pacemaker.
Yes _____ No _____

If yes, state:

1. Name and address of each person who treated you

   a. _____
   Name

   _____
   Address (if not otherwise provided)

   b. _____
   Name

   _____
   Address (if not otherwise provided)

   c. _____
   Name

   _____
   Address (if not otherwise provided)

2. Condition for which treated

   _____

3. When treated

   _____

VIII. LOSS OF INCOME

A. If you claim or expect to claim that you lost earnings or impairment of earning capacity as a result of any condition which you believe was caused by your Guidant implantable defibrillator and/or pacemaker:

1. Complete the following information with respect to your employment for the past five years.

Employers for Past Five Years	Address	Position	Dates of Employment

2. State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your Guidant implantable defibrillator and/or pacemaker and the amount of income which you lost._____

3. State your earned income for each of the last five years.

Year	Income
_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

B. State the amount of medical expenses you have you paid or incurred, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of a Guidant implantable defibrillator and/or pacemaker for which you seek recovery in this action. $_____

C. If you are making claims from out-of-pocket expenses as a result of the affected product, please complete the following:

1. What are the expenses for?" _____

2. Amount of fees or expenses: _____

DOCUMENT REQUEST

Attach the following documents to this declaration, to the extent that such documents are currently in your possession of your lawyers:

1. All press releases or other public statements made by you relating to this litigation or to your illness, injury, or medical condition that forms the basis of your Complaint.

2. All reports of any testing, including drafts and raw data, conducted on the Guidant implantable defibrillator and/or pacemaker that is the subject of your claim in this litigation.

3. All x-ray images depicting the location of the Guidant implantable defibrillator and/or pacemaker.

4. All documents referring or relating to your claimed damages.

5. Each informed consent form signed by you in connection with treatment by a health care professional and/or institution relating to any Guidant implantable defibrillator and/or pacemaker whether manufactured by Guidant or any other company.

6. All documents, including but not limited to, literature and/or warnings, received by you relating to any Guidant implantable defibrillator and/or pacemaker from any source.

7. All documents referring to or relating to your medical history over the past ten years, including, but not limited to, medical records.

8. All documents relating to your insurance coverage that are applicable to the illness, injury or medical condition which forms the basis of your Complaint, including any application to any insurer for coverage whether insurance was obtained or not.

9. All written, recorded or transcribed statements concerning this action made by any parties or witnesses, or their respective agents, servants or employees.

10. If you claim that you have suffered a bodily injury as the result of the use of a Guidant implantable defibrillator and/or pacemaker, all documents submitted to or received from the Social Security Administration, any workers' compensation agency, or any disability insurer concerning any disability claim you have made during the past ten years.

11. If you are making a claim for loss of earnings or loss of earnings impairment, your state and federal tax returns for the last five years and your employment records for the last five years.

12. Authorizations for the release of release of medical, employment, insurance and disability records for those entities identified in the above responses.

DECLARATION

I declare under penalty of perjury under the laws of the United States of America that all of the information provided in this Initial Disclosure is true and correct to the best of my knowledge. I further declare that I have supplied all the documents requested in part VII of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied authorizations for the release of medical, employment, insurance and disability records for those entities identified in these responses.

_____ _____

Signature Date

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO 45 C.F.R. 164.508

Patient Name: _____

Identification: Date of Birth_____ Soc. Sec. # _____
Parents Name/Previous Name(s) _____

Provider: Organization, Individual, or Class of Persons _____
(Who is releasing the information) Address (leave blank if used for Class of Persons _____
_____

Requestor: Name **SHOOK, HARDY & BACON LLP**
(to whom the information will be provided) Address _____
_____

Information Requested:

I authorize the disclosure of all protected medical information in any form (including oral, written and electronic) to Shook, Hardy & Bacon LLP, and Shook, Hardy & Bacon's redisclosure of the data and information to its consultants, experts, agents, and/or other counsel. I expressly request that all covered entities under HIPAA identified above disclose full and completed protected health information spanning the time period _____ to _____, including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or health care providers;
- All autopsy, laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram, electrocardiograms, pulmonary function tests, stress tests, angiograms, cardiac catheterization tapes, and cardiac catheterization reports;
- All radiology films; mammograms; myelograms; CT Scans; photographs; bone scans; pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens; cardiac catheterization videos/CDs/films/reels; echocardiogram videos; echocardiogram and electrocardiogram tracings in all forms including original films, copy of computer storage of the data on disk or tape and a copy of the records.
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs
- All billing records, including, but not limited to: all statements, itemized bills, and insurance records.
- All documents related to amendment of any record requested.

Purpose of Release: ” For the purpose of review and evaluation in connection with a legal claim. ” Other _____

This authorization is effective until (date)_____, or when the following event occurs: _____
_____. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Shook, Hardy & Bacon LLP. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Patient if 18 years of age or older _____ **Date** _____

Signature of Parent or Legal Representative _____ **Date** _____

Relationship to Patient, if not signed by Patient _____

SPECIFIC authorization for release of information protected by state or federal law. **In addition to the authorization and other provisions contained above, hereby incorporated by reference, I authorize: (i) the release of data and information to Shook, Hardy & Bacon LLP; and (ii) Shook, Hardy & Bacon LLP's re-disclosure of the data and information to its consultants, experts, agents, and/or other counsel; any and all data, notes, records, reports, and/or any other documents and information relating to:**

” 1. **Substance Abuse (Alcohol/Drug)** ” 2. **Mental Health (includes psychological testing)** ” 3. **HIV-related information (AIDS related testing)**

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient if 18 years of age or older _____ **Date** _____
Signature of Parent or Legal Representative _____ **Date** _____
Relationship to Patient, if not signed by Patient _____